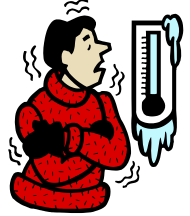


## Inside this issue....

- ▶ Fast and furious could describe the rate of change in the Indiana First Steps System. It is hard to keep up. This edition of the *Training Times* provides information current to the end of January. Service Coordinators and providers are encouraged to stay current with the changes through communication from their LPCC, Cluster SPOE and the state website.
- ▶ New CRO contracts and revised provider contracts are now in effect. A copy of the provider responsibilities from the individual provider contract (Rider A) is reprinted on page 12. As a contracted or employed member of a Provider Agency, the individual provider is responsible for meeting the obligations of Rider A.
- ▶ Ongoing service providers who provide developmental, occupational, physical and speech therapy must join a Provider Agency to receive authorizations for new services. These providers may continue to service current authorizations until they expire, up to 7/1/11. All other service providers, audiologists, dietitians, RNs, social workers, psychologists, vision and orientation mobility specialists have the option to join a Provider Agency or continue to practice as an independent provider. If they continue as an independent provider, they must have written referral agreements with Provider Agencies in the service areas where they work.
- ▶ Early literacy is critical to a child's development and future academic success. An Early Literacy Overview from Zero to Three is included on page 22. This March, UTS is offering a new training, Literacy in Therapy. Read more about it on page 13.



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**INDIANA'S UNIFIED TRAINING SYSTEM**

**"Creating Learning Opportunities for Families and Providers Supporting Young Children"**

# First Steps Enrollment and Credential Training Requirements

Provider Level - New	Training for Enrollment	Training for Initial Credential
Service Coordinator (Intake and Ongoing) New to First Steps December 2007 and after	SC 101—SC Modules (self-study)	SC 102 3-6 months after employment date SC 103 6-12 months after employment date Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 15 points for initial credential
Direct Service Provider (new to First Steps December 2007 and after)	First Steps Orientation or DSP 101—Provider Orientation Course (self-study)	DSP 102 - 1/2 day 3-6 months after enrollment (on-site) DSP 103 - 1/2 day 6-12 months after enrollment (on-site) Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Provider Level - Credentialed	Training for Enrollment	Training for Annual Credential
Service Coordinator (Intake or Ongoing who has completed initial credential)	SC Orientation and Service Coordination Level 1 or SC 101 – SC Modules (self-study)	Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential
Direct Service Provider (who has completed initial credential)	First Steps Orientation (on-site or self-study) or DSP 101 - Provider Orientation Course (self-study)	Quarterly (4) – Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential

## Attention: New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the quarterly *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (<http://www.utsprokids.org>) to register for UTS trainings. Obtaining an account is easy.

1. Click the Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click the Update Information.
5. Register for your annual training fee.

6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Janice in the UTS Connect office at: [registration@utsprokids.org](mailto:registration@utsprokids.org)

**Indiana First Steps**  
**UTS Training Times**  
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**Web Address:** <http://www.utsprokids.org>

**Email: Training questions** [training@utsprokids.org](mailto:training@utsprokids.org)

**Registration questions:** [registration@utsprokids.org](mailto:registration@utsprokids.org)

## Service Coordinator Training Dates for 2011

**Service Coordination 102:** All service coordinators must enroll and complete SC 102 3- 6 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to [training@utsprokids.org](mailto:training@utsprokids.org).

<b>Tuesday</b>	<b>March 8, 2011</b>	<b>ProKids, Inc. Indianapolis</b>	<b>9-4pm</b>
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**Service Coordination 103:** All service coordinators must complete SC103 6-12 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to [training@utsprokids.org](mailto:training@utsprokids.org).

<b>Tuesday</b>	<b>February 8, 2011</b>	<b>ProKids, Inc. Indianapolis</b>	<b>9-4pm</b>
<b>Tuesday</b>	<b>May 10, 2011</b>	<b>ProKids, Inc. Indianapolis</b>	<b>9-4pm</b>

All Service Coordinators must register online for SC 102 and SC 103 at [www.utsprokids.org](http://www.utsprokids.org).

## DSP 102 and DSP 103 New Provider Follow Up Orientation

All newly enrolled providers must complete the DSP series 101, 102 and 103 within the first year of their enrollment. DSP 101 is required for provider enrollment. DSP 102 must be completed three to six months following the provider enrollment date and DSP 103 must be completed six to twelve months following the provider enrollment date. Completion dates for these courses must be documented on the Annual Attestation Statement. The training dates for DSP 102 & 103 are listed below. Usually these trainings are held on the first Tuesday of each month at ProKids Inc. Since there are specific timelines for completion of DSP 102 and DSP103, that allow time for experience in the First Steps System, **providers may NOT take both courses on the same day.**

<b>DSP 102 Dates</b>	<b>Time</b>	<b>DSP 103 Dates</b>	<b>Time</b>
March 1, 2011	1:00-4:00 PM	March 1, 2011	9:00-12:00 PM
April 5, 2011	1:00-4:00 PM	April 5, 2011	9:00-12:00 PM
May 3, 2011	1:00-4:00 PM	May 3, 2011	9:00-12:00 PM

## AEPS 2-DAY Certification Course

This course provides a 2 day, comprehensive overview of the Assessment, Evaluation and Programming System (AEPS) for Infants and Children. The AEPS is a criterion-referenced developmental assessment tool for children, birth to six years. This course is required for all ED Team members. The 2-day AEPS course may also be used as a First Steps Core Training (FSCT) for your First Steps initial or annual credential. **Cost: \$75**

**February 16 & 17, 2011**

Check the UTS website for future AEPS training dates: [www.utsprokids.org](http://www.utsprokids.org)

## Additional Opportunities for Credential Points

Providers may utilize trainings (on-site and self-study) and conferences outside of UTS to meet their initial or annual credential points as long as the training is related to provider or service coordinator competencies and it is relevant to infants through age 6. These may include training offered at the SPOE Provider Meetings, association conferences (APTA, ASHA, etc.), hospital based conferences or grand rounds, other local, regional and national conferences, and books, videos and online training. You must keep a copy of the agenda or brochure that includes date, speakers, an agenda/content information and the time spent in the sessions you attended or a one page summary of the self-study training in your credential file. More information on credentialing can be found in the recently revised Personnel Guide at

<http://www.eikids.com/in/matrix/docs/pdfs/First Steps Personnel GuideRevised 12-2010.pdf>

# AN UPDATE ON THE CHANGES TO INDIANA FIRST STEPS

Change	Effective Date	Overview
<b>Administrative</b>		The First Steps office has moved to a new location in the State Government Center. The new address is: BCDS-First Steps, 402 W. Washington St., W453, MS-51, Indianapolis, IN 46204-2739. General email is <a href="mailto:FirstStepsWeb@fssa.in.gov">FirstStepsWeb@fssa.in.gov</a> . The state has two new consultants: Jeremy Hawk (Jeremy.Hawk@fssa.IN.gov) and Natasha Pulley (Natasha.Pulley@fssa.IN.gov).
<b>ED Teams</b>	1/1/11	ED Team members must be employed or contracted through the SPOEs. All referred families consenting to move forward will continue to receive an EDT evaluation and assessment prior to their eligibility meeting and IFSP development. Allowable time for the EDT evaluation and assessment has been decreased and ongoing EDT reviews will be performed only as needed. Any new request to add OT, PT or SLP services to a child's IFSP, will require an evaluation by an EDT member of the same discipline. Annual eligibility evaluation and assessment may be performed by one EDT member for those children with an eligible diagnosis. The EDT Manual is currently being revised.
<b>Provider Agencies</b>	1/1/11	<p>Only those providers from the following 4 disciplines (Developmental, Occupational, Physical, and Speech therapies, in an approved, enrolled Provider Agency may receive new authorizations for services. DT, OT, PT &amp; SLP providers with current authorizations may continue to provide services until their authorizations expire or July 1, 2011 (whichever is first).</p> <p>Current children with providers from different networks, will need to identify a "lead" agency. That agency will then be responsible for providing any additional services that the child and family may need. "Initial IFSPs written after Jan 1, 2011, must have services written through a Provider Agency and all providers for that child must be from the same Agency. In the event that an agency is not available, the SPOE supervisor and State will work collaboratively to determine if a multidisciplinary agency in another service area or one who is in the process of enrollment is available. <u>At no time however may the SC offer a provider outside of the service area or who is not enrolled as part of a multidisciplinary agency prior to obtaining approval for the state and their supervisor."</u></p> <p>Provider Agencies and their (DT, OT, PT &amp; SLP) providers were required to sign new CRO contracts and Riders. Providers should review both the CRO agency and Rider A documents to insure that they are in compliance. Complete copies of the Provider Agency Agreement and Rider A Provider Agreement can be found at <a href="http://www.eikids.com/in/matrix/docs/enrollment.asp">http://www.eikids.com/in/matrix/docs/enrollment.asp</a>. An excerpt of the provider responsibilities is reprinted on page 12.</p> <p>All other service providers, audiologists, dietitians, RNs, social workers, psychologists, vision and orientation mobility specialists have the option to join a Provider Agency or continue to practice as an independent provider. If they continue as an independent provider, they must have written referral agreements with Provider Agencies in the service areas where they work.</p>
<b>Provider Rates</b>	12/1/10	All provider rates were decreased by 5%. New rate charts have been posted at <a href="http://www.eikids.com/in/matrix/docs/enrollment.asp">http://www.eikids.com/in/matrix/docs/enrollment.asp</a>

Change	Effective Date	Overview
<b>3 month authorizations</b>	12/1/2010	Authorizations for IFSP services will only be written for 3 month periods. A detailed chart of the authorization timeline and progress note due dates can be found on page 6. The first authorization end date is based on the initial IFSP date with subsequent auth end dates based on the authorization start date. Providers will not be reauthorized for services, if they do not submit timely progress notes, indicating a need for continued services.
<b>High Intensity Services</b>	10/1/2010	Services occurring more than 1 time a week or more than 60 minutes per session must have IFSP and EDT agreement, in addition to state prior approval (PA). It is the requesting provider's responsibility to submit the necessary paperwork to the service coordinator, who will submit the PA packet to the state.
<b>Cost Participation Suspension of Services</b>	10/1/2010	<p>Families who are 60 days or more past due with their co-payments are notified the first week of the month that their child's services will be suspended if their account is not paid by the due date. Families with old insurance issues must continue to remit their current monthly co-pay, until the insurance issues have been settled. Families experiencing a hardship may request a payment plan. All payment plans must be approved by the state and parents must remain current with their payment plan.</p> <p>Providers are notified when families are subject to suspension. Service authorizations are canceled for families who fail to pay. Once the family's account is confirmed to be current, the service coordinator will contact the family and obtain a new service change page to reinstate services. The process to reinstate services may take up to 30 days to complete.</p>
<b>Increased Parent Participation</b>	11/1/2010	Parents and caregivers are required to fully participate in each therapy session. Families with children who receive services outside of their care, such as those receiving services while in child care, need to need to develop plans for their participation on a regular basis (once a month or every 4th visit) and discuss any barriers to participation with the child's providers and service coordinator. This discussion must be documented.
<b>New DT enrollment requirements</b>	12/1/10	Newly enrolled DTs must meet the revised enrollment criteria. Current DTs who do not meet the new enrollment criteria must request a waiver from the state if they are changing enrollment. The revised Personnel Guide (dated 12/1/10) is posted at <a href="http://www.eikids.com/in/matrix/docs/enrollment.asp">http://www.eikids.com/in/matrix/docs/enrollment.asp</a>

### IFSP Team Decision-Making

IFSP development should be based on the child's needs and appropriate level of services. When services are always written for one time weekly for 60 minutes are they really individualized to the specific needs of the child and/or family? The State has asked EDTs and ongoing providers to think outside the box in order to consider how services can be provided effectively and efficiently. This may include consultative services or services provided monthly or semi-monthly.

IFSP service decisions are determined by consensus of the IFSP team, including the parents. Majority does not rule. Consensus decisions are those that the team members can all live with, even though it may not be what an individual team member recommended.

## IFSP 3 Month Authorizations and Progress Notes Procedures

1. Effective 12/1/10, IFSP service authorizations can only be written for 3 month periods. All authorization periods are based on the month that the initial/annual IFSP is written and signed by the parent.
2. The initial authorization start date will be according to Cluster policy to allow for physician signature and will end the last day of the 4<sup>th</sup> month to allow for the 30 day start period.
3. All subsequent authorizations will begin on the first day of the month and end of the last day of the month as noted in Attachment A – Authorization and Report Schedule.
4. Providers must submit progress notes on the first day of the month due. Providers will not be reauthorized for services, if they do not submit timely progress notes.
5. Providers must also provide a discharge report when the child is discharged from services or leaves the First Steps System.

### Attachment A-- Authorization and Report Schedule

Initial/Annual IFSP meeting month:	3 month auth ends	6 month auth ends	9 month auth ends	12 month auth ends
January	4/30/--	7/31/--	10/31/--	Last day of IFSP
February	5/31/--	8/31/--	11/30/--	Last day of IFSP
March	6/30/--	9/30/--	12/31/--	Last day of IFSP
April	7/31/--	10/31/--	1/31/--	Last day of IFSP
May	8/31/--	11/30/--	2/28/--	Last day of IFSP
June	9/30/--	12/31/--	3/31/--	Last day of IFSP
July	10/31/--	1/31/--	4/30/--	Last day of IFSP
August	11/30/--	2/28/--	5/31/--	Last day of IFSP
September	12/31/--	3/31/--	6/30/--	Last day of IFSP
October	1/31/--	4/30/--	7/31/--	Last day of IFSP
November	2/28/--	5/31/--	8/31/--	Last day of IFSP
December	3/31/--	6/30/--	9/30/--	Last day of IFSP

Initial/Annual IFSP meeting month:	3 month report due:	6 month report due:	9 month report due:	Annual report due:
January	4/01/--	7/01/--	10/01/--	1/01/--
February	5/01/--	8/01/--	11/01/--	2/01/--
March	6/01/--	9/01/--	12/01/--	3/01/--
April	7/01/--	10/01/--	1/01/--	4/01/--
May	8/01/--	11/01/--	2/01/--	5/01/--
June	9/01/--	12/01/--	3/01/--	6/01/--
July	10/01/--	1/01/--	4/01/--	7/01/--
August	11/01/--	2/01/--	5/01/--	8/01/--
September	12/01/--	3/01/--	6/01/--	9/01/--
October	1/01/--	4/01/--	7/01/--	10/01/--
November	2/01/--	5/01/--	8/01/--	11/01/--
December	3/01/--	6/01/--	9/01/--	12/01/--

## 3 Month Authorizations Process Review

- Initial IFSP is developed by the IFSP team (EDT, PCP, SC and Parent)
  - Providers are identified and authorization is written. The initial authorization start date will be according to Cluster policy to allow for physician signature. The end date will follow Attachment A schedule based on the month of the IFSP meeting date.
  - All IFSPs are now reviewed quarterly
- A. **First Quarter Review**
1. Service Coordinator will send 10 day written prior notice to the family and IFSP team prior to quarterly review. The First Quarter review can be conducted face-to-face, via telephone or other electronic means, per Cluster policy and noted on the 10 day WPN.
  2. Service Coordinator receives and reviews the Provider Progress Report for the child. The Provider Progress Report is to be submitted as a “team” report if the child is authorized for more than one IFSP service. This report is to be sent electronically from the provider/provider agency on the first day of the month in which the authorization is due to expire.
  3. **Providers who do not submit progress notes will not be re-authorized.** The Service Coordinator will explain to the family that authorizations cannot be written if there is no provider report and that the service will end on the authorization expiration date. If the provider continues services, they will not be reimbursed. The Service Coordinator will notify the Provider Agency to inform them of the service end date. A copy will be forwarded to the LPCC Coordinator for inclusion in the cluster’s concern/complaint log. If the provider submits a late report, the service coordinator will review the report and document the discussion with the family. If services are appropriate to continue a new authorization will be written on a service change page. The start date will be the date the form is returned with the parent signature, the end date will follow the authorization schedule for the date of the initial or annual IFSP.
  4. Reports that clearly demonstrate progress and continuing need for service do not require EDT review. A Service Coordinator may ask for EDT review if there is a question regarding the discontinuation and/or reauthorization of service.
  5. If EDT review is needed, the Service Coordinator will issue an EDT authorization for review time. EDT review times are no longer issued with the IFSP and must be individually authorized based on need.
  6. Service Coordinator meets with family (face-to-face, via telephone or other electronic means) to discuss progress reports and IFSP services. This meeting is documented in writing. Specific documentation guidelines may vary and may include SC log, meeting minutes, outcome review form, etc.
  7. A change page is completed for IFSP services. The change page is signed by the parent, an original signature is required (this may be sent via mail). If no new services are added, a physician signature is **NOT** required. If new services have been added or increased, the change page must be signed by the physician. The authorization end date and progress note schedule for any newly added services should be same as for all other IFSP services.
- B. **Second Quarter Review** - Same as the First Quarter Meeting (see above), with the following exceptions:
1. This is a face-to-face meeting with the family.
  2. The Service Coordinator will complete the 6<sup>th</sup> Month Packet
  3. Since the IFSP was already reviewed in the first quarter, the 6<sup>th</sup> month meeting must be completed before the end date for the service authorizations.
- C. **Third Quarter Review**—Same as the First Quarter Meeting (see above), with the following exceptions:
1. This is a face-to-face meeting with the family.
  2. This meeting serves as annual IFSP preparation. The Service Coordinator will obtain new consents, income, insurance information, Physician’s Health Summary, and any other pertinent updates (new family members, address changes, etc.)
  3. The annual EDT evaluation will be scheduled.
- D. **Annual IFSP meeting**
1. Service Coordinator sends 10 day written prior notice to the family and IFSP team. This is a face-to-face meeting with the family.
  2. Service Coordinator receives and reviews the Annual EDT Assessment Summary and Provider Progress Report for the child. The Provider Progress Report is to be submitted as a “team” report if the child is authorized for more than one IFSP service. This report is to be sent electronically from the provider/provider agency on the first day of the month in which the authorization is due to expire.
  3. If the ongoing providers do not submit progress notes, the EDT evaluation will be used for IFSP development. Families may choose new providers for IFSP services. The service coordinator will notify the LPCC Coordinator of the provider’s failure to submit progress reports for inclusion in the cluster’s concern/complaint log.
  4. The Service Coordinator will obtain the PCP (MD) signature on the IFSP authorization page. The newly developed annual IFSP will follow the authorization and progress report schedule in Attachment A.

# State Rolls Out Revised Progress Forms

The state recently revised the Provider Progress Report. The revised report is posted under the What's New section of the state webpage at [http://www.in.gov/fssa/files/Progress\\_Report\\_2011.rtf](http://www.in.gov/fssa/files/Progress_Report_2011.rtf). The report is titled, "Evaluation/Progress Report". Providers should complete transition to the use of the new report form no later than 7/1/11. For children with more than one authorized provider, the provider progress report is to be submitted to the SPOE as a team report. The report is reprinted on pages 9-11 for review only, please do not reprint the progress report from this edition of the Training Times. Providers must download the report from the state website in order to electronically send the completed report to the SPOE.

## Progress Report Form Directions

*This report is intended to serve as a comprehensive team report to be completed by all members of the child's team. The treatment orders and services reflected in the Report should be as listed on the IFSP. The correlating diagnosis should also be listed.*

The progress reports are due to the SPOE/Service Coordinator at the beginning of the month, following the Authorization/Progress Report schedule (attachment A). Once the form is complete, you must save the document and name the file for easy retrieval, for example "Jane Smith 3Q". You should send it to your local SPOE office following their specific procedures for submitting progress reports. Because SPOE procedures vary, if you need clarification of who/where to email the report, you should contact your Service Coordinator. If you are added to the plan later, you are still responsible for adhering to the same timelines as the other team members for progress reports. For instance, if your specialty is added at the 6- month review, your first progress report will be due at the 9 month date. You should mark this as the 9 month report like other team members.

**Report header:** The report header contains the child name, DOB and First Steps number. You only need to double click the area and enter the correct information. This information will then appear at the top of each page.

### Child Information:

**Adjusted Age--** Only adjust if greater than 4 weeks premature and less than 2 years of age.

**Diagnoses and ICD9 Codes--** You must include the diagnoses most appropriate for the services you are providing and the corresponding ICD9 codes. These include the diagnoses found in the Physician Health Summary, page 2 of the IFSP and any additional diagnoses you have received from the physician and those other diagnoses/conditions/symptoms that you may report under your license and practice act.

**Onset Date--** For the diagnosis/condition you are treating.

**Precautions/Contraindications--** Include any special measures/modifications taken because of child's condition.

**IFSP Date--** Current IFSP date for this report. IFSPs are re-written annually and this date must be updated.

**Date of First Treatment--** This is the date first seen for the current IFSP.

**Attendance this period--** number of treatment sessions for the period of this report only.

**PCP and contact info--** Child's primary care physician. Should be the same physician who signs the IFSP.

**Report Date:** This should be the date you complete the form. Please mark which report period you are commenting on for the child and enter your discipline.

### Team Information:

**Family Information--** Please list the information in the fields. For kids with multiple household addresses, please list the primary parent.

**Provider Information--** Please list all team members, with yourself first. Be sure to include the physician.

**Services:** Include the specific authorization for your service, including discipline, frequency and duration.

### IFSP Goals/Outcome Review:

**Functional Status--** Describe the child's current functional status, with specific information as it applies to the services you provide (i.e. PT focus on gross motor, SLP on oral motor status).

**Discharge Goal--** What needs to occur for this child to no longer need your services.

**Long Term Goals (IFSP Outcomes)--** IFSP Goals for the services you are providing.

**Short Term Goals--** These are your therapy goals for the authorization period. Include date set, baseline, expected resolution, current level and the status of the STG (achieved, partially met, etc.).

**Notes:** Include any other pertinent information about the child and family as it relates to services received and progress made for the reporting period.

**Signature:** You may use an electronic signature that includes your title and date of the report. Keep a copy of the original signed report.

**MD Certification:** This is optional since the physician has signed the certification on the IFSP and/or change page.

## First Steps Evaluation/Progress Report

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ First Steps ID#: \_\_\_\_\_

Chronological Age: \_\_\_\_\_ Adjusted Age: \_\_\_\_\_

Treating Diagnoses and ICD9 code(s): \_\_\_\_\_

Onset Date: \_\_\_\_\_

Precautions/Contraindications: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

Date of first treatment: \_\_\_\_\_

Attendance this period: \_\_\_\_\_

PCP and contact information: \_\_\_\_\_

**Report Date:**  
**Discipline(s):**

**Report Type:**

☐ Evaluation

☐ Initial – Q1

☐ Quarter 2

☐ Discharge

☐ Quarter 3

☐ Annual -- Q4

☐ Other:

### Team Information

#### Family Information

Parent / Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

#### Provider Information

Service Coordinator: \_\_\_\_\_ Email: \_\_\_\_\_

ED Team Lead: \_\_\_\_\_ Email: \_\_\_\_\_

Team Members-- including all providers and ED Team members (list reporting provider first): \_\_\_\_\_

### Services

#### First Steps services (add lines as needed)

Treatment Order/Services: \_\_\_\_\_ Treating Diagnosis: \_\_\_\_\_

Frequency: \_\_\_\_\_ Session length: \_\_\_\_\_ Duration: \_\_\_\_\_

Treatment Order/Services: \_\_\_\_\_ Treating Diagnosis: \_\_\_\_\_

Frequency: \_\_\_\_\_ Session length: \_\_\_\_\_ Duration: \_\_\_\_\_

January 2011

Page #:

## First Steps Evaluation/Progress Report

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ First Steps ID#: \_\_\_\_\_

Additional services

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### IFSP Goals/Outcome Review

Functional Status:

Discharge Goal:

Long Term Goals (IFSP Outcomes):

Outcome #

Outcome #

Outcome #

Short Term Goals:

#

Date set: \_\_\_\_\_ Expected Resolution: \_\_\_\_\_ Status: \_\_\_\_\_

Baseline:

Current Level:

#

Date set: \_\_\_\_\_ Expected Resolution: \_\_\_\_\_ Status: \_\_\_\_\_

Baseline:

Current Level:

#

Date set: \_\_\_\_\_ Expected Resolution: \_\_\_\_\_ Status: \_\_\_\_\_

Baseline:

Current Level:

---

Additional Notes:

## First Steps Evaluation/Progress Report

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ First Steps ID#: \_\_\_\_\_

\_\_\_\_\_  
Therapist Name                      Therapist Signature                      Date:

\_\_\_\_\_  
Therapist Name                      Therapist Signature                      Date:

\_\_\_\_\_  
Therapist Name                      Therapist Signature                      Date:

**Therapists are to review this progress report with the parent/caregiver and provide them with a signed copy. Date copy of this report was shared / will be shared with parent/caregiver:**

### Physician Plan of Treatment

**I certify that continued treatment for \_\_\_\_\_ as outlined by the IFSP is necessary for the proper treatment of this patient.**

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

(Toddlers, continued from page 21)

"This is the first randomized controlled trial to examine an intervention focused on core social deficits of ASD in toddlers, and the first to show gains in these deficits resulting from intervention," said Landa. "Though preliminary, our findings provide promising evidence that such a supplementary curriculum can help improve social and communication skills in children younger than 3 who have ASD.

The researchers received additional study funding from the Health Resources and Services Administration.

#### Reference:

Landa, RJ, Holman, KC, O'Neill, AH, Stuart EA. Intervention Targeting Development of Socially Synchronous Engagement in Toddlers with Autism Spectrum Disorder: A Randomized Controlled Trial. J Ch Psychol Psychiatry. 2010 Dec 8. [pub ahead of print]

### New Web Site on Hearing Loss in Children

The CDC site is available at <http://www.cdc.gov/hearingloss>



### Daylight Savings Time

**Spring ahead March 13, 2011.** [Daylight Savings Time](#) (DST) begins on the second Sunday in March at 2:00 am local time in the U.S., which in 2011 is March 13. Turn clocks ahead by one hour, ideally at bedtime on the Saturday night before.

## Rider A—Provider Responsibilities

### ***B. The Service Provider agrees to:***

1. Be knowledgeable of and abide by all applicable federal and state laws, rules, regulations, policies and procedures related to the First Steps Early Intervention Services System (First Steps) including but not limited to 20 U.S.C. §1431 et seq.; 34 C.F.R. Part 303 (Individuals with Disabilities Education Improvement Act--Early Intervention Program for Infants and Toddlers with Disabilities); 34 C.F.R. Part 99 (Family Education Rights and Privacy Act (FERPA)); 34 C.F.R. Part 104 (Nondiscrimination on the Basis of Handicap); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); the Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.); PL 104-191 (Health Insurance Portability and Accountability Act of 1996 (HIPAA)); 470 IAC 3.1 and IC 12-17-15 (First Steps Early Intervention System);
2. Continually meet and maintain all applicable and necessary standards, regulations, procedures and minimum personnel requirements for licensing, credentialing, program licensure and funding requirements for services provided. This expressly includes the assurance by the Service Provider that he/she will complete all obligated licensure and enrollment requirements. The Service Provider will also submit a provider annual update, and complete credentialing activities within two (2) years of enrollment with the Central Reimbursement Office (CRO). The Service Provider understands and agrees that invoices will not be paid without proper licensing and credentialing activities completed;
3. Attend and participate in all mandatory statewide provider forums;
4. Provide service(s) to eligible children and their families upon referral as set forth in the Individualized Family Service Plan (IFSP) within the service areas as listed in Exhibit 1, and/or upon receipt of an authorization for evaluation and assessment services as provided by the System Point of Entry (SPOE);
5. Participate in planning, development, review, and revision of IFSPs for children covered under this Agreement in a timely and comprehensive manner. Service Providers must ensure that all modifications to an existing IFSP are made through the child/family's assigned Service Coordinator and the IFSP process; and understand that they may not bill or receive reimbursement for services in excess of what is reflected on the IFSP and subsequent authorization;
6. Notify the assigned Service Coordinator, in writing, of any planned or recommended changes in the delivery of services to eligible children under this Agreement, including the termination of services prior to the end of the period of service as reflected on the IFSP. The Service Provider shall provide fourteen (14) days notice to the child's Service Coordinator prior to termination of services;
7. Complete and respond in a timely manner to Third Party Liability (TPL) requests per state procedures, including but not limited to: verifying TPL coverage of services for individual children served, and the utilization of appropriate and accurate ICD-9 codes;
8. Provide progress notes in adherence to current state procedures regarding eligible children and their services to the individual child's Service Coordinator. The provider understands and agrees that invoices may not be paid in the absence of routine submission of progress notes;
9. Obtain accurate HIPAA compliant clinical records, including original Face to Face forms and all other documentation to support the delivery of services and payment, for a period of at least seven (7) years from a child's discharge from service or transition from First Steps;
10. Make available and accessible to state personnel, and their agents, all records and information necessary to assure the appropriateness of payments made to the Provider and to assure the Service Provider's compliance with all applicable statutes and regulations. Such records and information shall be kept in Indiana and include, without being limited to, the following:
  - a. medical records
  - b. financial records
  - c. records of all services for which payments have been made, or are to be made, by the CRO, including all claims support documentation (may include: Face to Face sheets and calendars/appointment books) as required by First Steps
  - d. Provider credentialing records;
11. Provide original Limited Criminal History from the Indiana State Police documentation to Provider enrollment contractor at time of enrollment and maintain a copy in Provider personnel files;
12. Provide accurate information for the statewide service provider matrix and update Service Provider's availability at least monthly or as changes occur.

### ***D. The Service Provider and DDRS mutually agree to:***

1. Ensure the provision of services using appropriately credentialed and/or licensed providers, and to maintain the integrity of the IFSP process through accurate and timely implementation of the services as mutually determined and agreed to by the IFSP Team, and consented to in writing by the child's parent/legal guardian. It is expected that services will start within 30 days of the date of the parent signature on the IFSP;
2. Ensure that services are family-centered, inclusive and culturally competent, understanding the importance of involving the child and family members in service planning and in the development of outcomes identified in the IFSP;
3. Ensure effective implementation of procedural safeguards for each eligible child and family, pursuant to federal and state statutes and regulations;
4. Ensure that family members/caregivers are knowledgeable about and actively involved with the services being provided, according to current procedures, in addition to transition activities into, within, and from the service delivery system;

# Training Opportunities

## **NEW FSCT Trainings:**

### **FSCT - Hey Kids, Let's Play: June 10, 2011**

From the authors of Mommy the T.V.'s Off...Now What? This training targets Service Coordinators and Developmental Therapists new to early intervention, highlighting infant and toddler development, atypical development, and activities and strategies in providing First Steps services.

**FSCT It's Online, but Can I Trust It?** February 18, 2011 in Columbus, IN; February 25, 2011 in Corydon, IN; March 25, 2011 in Ft. Wayne, IN; April 29, 2011 in Lafayette, IN; and May 6, 2011 in Indianapolis.

Who do you trust? Find out how to identify authoritative sources while developing a toolkit of go-to resources for education and health information. Christina Wray is from Center for Disability Information and Referral through the Indiana Institute on Disability and Community

Seminar Objectives:

1. Identify authoritative sources online.
2. Develop a toolkit of free online resources in health and education.
3. Learn how to utilize InSPIRE to access scholarly works in your subject area.

### **FSCT – Literacy into Therapy - March 3, 2011 in Muncie, IN**

All early interventionists play a vital role in the development of the infants and children we service. As providers, we not only affect a child's current development, we also have the ability to shape a child's future academic and social success. Incorporating literacy into therapy goals allows us as providers to meet the developmental needs, abilities and interests of the children we serve. This training session is an interactive look for all disciplines on why and how literacy can be incorporated into oral language, gross and fine motor and social activities.

## **Upcoming Face-to-Face FSCTs**

February 16 & 17, 2011 – **AEPS 2-Day Certification Course**

February 22, 2011 – **FSCT – Understanding Diversity within Families**

April 15, 2011– **FSCT – AEPS: An Overview (Onsite)**

## **Available Online First Steps Core Trainings**

FSCT – AEPS: An Overview

FSCT – A Family-Centered Approach to Procedural Safeguards

FSCT – Direct Service Provider Refresher Course

FSCT – Providing EI Supports and Services in Everyday Routines, Activities, and Places

FSCT – Understanding and Implementing Positive Transitions for Children and Families in Early Intervention



# Your Child's Development

This is an exciting time as older toddlers are using their growing language skills to tell you what they are thinking and feeling. They are also building friendships with other children. And their growing physical skills—walking, running, and climbing—help them explore the world in more adventurous ways. *What do you find most amazing about your child's development at this stage?*

What Your Toddler Can Do	What You Can Do
<p><b>I use my body to get me places!</b></p> <ul style="list-style-type: none"> <li>• I can walk up stairs one foot at a time.</li> <li>• I can walk backward.</li> <li>• I can balance on one foot which helps me climb.</li> </ul>	<p><b>Go on a neighborhood walk.</b> Let your child stop to check out what's interesting to her.</p> <p><b>Play "island hop."</b> Line up pieces of paper on the floor and help your child jump from one to the next.</p>
<p><b>I am using language to tell you what I'm feeling and thinking.</b></p> <ul style="list-style-type: none"> <li>• I can make longer sentences: <i>Mama play truck?</i></li> <li>• My favorite words may be <i>no</i>, <i>me</i>, and <i>mine</i>.</li> <li>• I may get overwhelmed by my strong feelings and have trouble putting them into words. I might need your help to calm down.</li> </ul>	<p><b>Ask about your child's ideas:</b> <i>What part of the book did you like?</i></p> <p><b>Acknowledge feelings and teach social skills at the same time:</b> <i>I know the doll stroller is your favorite toy, but Thomas would like a turn pushing it.</i></p> <p><b>Help your child recover from a tantrum.</b> Some children respond to being comforted. Others do better with some alone time in a safe, quiet place.</p>
<p><b>I am getting really good at playing pretend.</b></p> <ul style="list-style-type: none"> <li>• I can use one object to stand in for another. A shoebox may become a bed for my stuffed hippo.</li> <li>• I laugh at silly things, like the idea that my toy car might go <i>moo</i> instead of <i>beep beep</i>.</li> <li>• Sometimes I get scared. I am getting so good at using my imagination but am not always sure what's real and what's pretend.</li> </ul>	<p><b>Use pretend play to help your child handle challenging situations.</b> You might act out a story together about meeting a new babysitter.</p> <p><b>Let your child lead the play.</b> Ask: <i>Who should I be? What will happen next?</i></p> <p><b>Respond sensitively to your child's fears.</b> Explain what is real and pretend. This builds trust and security.</p>
<p><b>I want to make friends but still need help with sharing.</b></p> <ul style="list-style-type: none"> <li>• I like watching other children and may copy what I see them do.</li> <li>• I may have one or two good friends.</li> </ul>	<p><b>Give your child regular chances to play with children her age.</b> This builds social skills.</p> <p><b>Help your child with conflicts around sharing and turn-taking.</b> Let her know you understand that sharing is hard. Help her find another toy to play with until it's her turn. Use a kitchen timer to help her learn to wait.</p>



As you use this resource, remember that your child may develop skills faster or slower than indicated here and still be growing just fine. Talk with your child's health care provider or other trusted professional if you have questions.

Your family's cultural beliefs and values are also important factors that shape your child's development.

For more information on parenting and child development, go to: [www.zerotothree.org](http://www.zerotothree.org).

### What's on Your Mind

My 28-month-old son screams until I give in to his tantrums. What can I do?

Tantrums are common among toddlers. They happen when children have lost their ability to handle a difficult situation, such as having something they want denied. Help your child manage frustration by:

- Acknowledging his feelings: *I know you are mad that you can't have more ice cream. It's okay to feel mad. When you calm down, we can figure out what to do next.*
- Offering choices: *Would you like an apple or a banana?*
- Using humor: *Mr. Apple wants you to eat him. Oh no, now Miss Banana is pushing apple out of the way so you will choose her instead!* Humor cuts the tension and helps children calm down.

*How does your child handle frustration? What calms him down?*

### Did You Know...

That toddlers who are learning more than one language reach their speech milestones at about the same time as children who speak only one language.<sup>3</sup>

### What It Means for You:

Toddlers can learn two languages at once. At first, they may say fewer words in each language, but this doesn't mean they have a language delay! Research shows that when you add together the words toddlers know in both languages, their vocabulary is about the

same as children who speak only one language. Some parents may also worry that children will lose their home language if they hear a different language in their child care setting. Research shows that as long as parents use their home language regularly, children's home language skills continue to grow.<sup>4</sup>

## Spotlight on Learning to Use the Toilet

When and how you help your child learn to use the potty depends on how ready your child is. Your culture—your family's beliefs and values about toilet training—also matters. There is not one "right" way to toilet train your child.

- Most children develop control over their bowels and bladder by 18 months. This is necessary for children to physically be able to use the toilet. How emotionally ready a child is to use the potty depends on the individual child.<sup>1</sup>
- Starting to train your child earlier does not necessarily mean she will learn to use the potty sooner. One study showed that children whose parents started training them before 27 months took longer to learn to use the potty compared to children whose parents started after 27 months.<sup>2</sup>
- Finding a toilet training method that works for your family is the key. No matter how you do it, remember that potty training takes time, with many accidents along the way.
- Children with special needs may take longer to learn to use the potty. They may also need special equipment and a lot of help and patience from you. For questions about toilet training, talk with your health care provider or early intervention specialist.

- Parents and children each have their own "jobs" to do when it comes to potty training. Parents are responsible for creating a supportive learning environment.

#### Parents:

- ✓ Respect that your child is in control of her body.
- ✓ Ask your child whether she wants to use the potty or wear a diaper/pull-up each day.
- ✓ Teach your child words for body parts, urine, and bowel movements.
- ✓ Offer your child the tools—a small potty, potty seat, stool—necessary to succeed at toileting.
- ✓ Handle potty accidents without anger.
- ✓ Avoid punishment as well as too much praise around toilet use.

#### Your child:

- ✓ Decides whether to use the toilet or a diaper/pull-up.
- ✓ Learns her body's signals for urine and bowel movements.
- ✓ Uses the toilet at his own speed.



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Photo credit: Eyewire/Babies/Getty Images

A photograph of a man with dark hair, wearing a grey shirt, leaning over a baby. The baby is lying on a colorful blanket with red, green, and yellow sections. The man is looking down at the baby with a gentle expression.

## Understanding Your Child's Behavior: Reading Your Child's Cues from Birth to Age 2

### Does this Sound Familiar?

**J**ayden, age 9 months, has been happily putting cereal pieces into his mouth. He pauses for a moment and then uses his hands to scatter the food across his high chair tray. He catches his father's eye, gives him a big smile, and drops a piece of cereal on the floor. When his father picks it up, Jayden kicks his legs, waves his arms, and laughs. He throws another piece of cereal. His dad smiles and says, "Jayden, it looks like you are all done eating. Is that right?" He picks Jayden up and says, "How about we throw a ball instead of your food, okay?"

Naomi, age 30 months, is happily playing with her blocks. All of a sudden, her mother looks at the clock, gasps, and says, "Naomi, I lost track of time! We need to go meet your brother at the school bus! Let's go." She scoops Naomi up and rushes toward the kitchen door. Naomi shouts, "NO!" and tries to slide out of her mother's arms to run back to her blocks. When her mother puts on Naomi's sneakers, she kicks them off, slaps her mother's hands, and repeats, "No! I STAY! I playing blocks!" Naomi's mother sighs with frustration and buckles her into the stroller with no shoes. This sets off another round of protests: "My SHOES! Where my SHOES?" Naomi pulls at her stroller's buckle, trying to unfasten it, and kicks, screams, and cries all the way to the bus stop.

## The Focus

Babies and toddlers might just be learning to talk—but they have many other ways to tell parents how they are feeling! Children can experience the same emotions that adults do, but they express those feelings differently. Jayden is giving his father many clues that he is done eating. First, he begins to play by sweeping the food across his tray. Then he drops food on the floor in an attempt to get his Dad to play the "I Drop It, You Get It" game. Jayden's father notices and responds to these "cues," by calling an end to mealtime and giving Jayden a chance to play. Naomi is also very clear about her feelings. She doesn't like having to make a transition from a fun activity (blocks) so quickly. She is giving her mother many "cues" too—her words, facial expressions, and actions are all saying, "This transition was too quick for me. I



was having fun and I can't move on so quickly."

Children's behavior has meaning—it's just that adults don't always understand what the meaning is. In the early years, before children have strong language skills, it can be especially hard to understand what a baby or toddler is trying to communicate. This resource will help you better understand your child's behavior cues and help you respond in ways that support his or her healthy social and communication development.

## What to Expect: Communication Skills

### Birth to 12 Months

Did you know that crying is really just a baby's way of trying to tell you something? Your baby's cry can mean many different things, including, "I'm tired," "I don't know how to settle myself," "I'm in pain or discomfort," or "I want the toy you just picked up." In the first year, babies will gradually begin to use gestures and sounds to communicate. But many parents find the first 12 months one of the most difficult times to understand the meaning of their babies' behaviors. Below are some common ways babies communicate. With time, you will figure out your baby's unique way of communicating.

**Sounds:** Crying is your baby's primary communication tool. You might find that your baby uses different cries for hunger, discomfort (like a wet diaper), or pain (like a tummy ache). Paying attention to the sounds of these cries helps you make a good guess about what your baby is trying to communicate.

**Language:** Right around the one-year mark (for some babies earlier, and for some babies later), your baby will say his or her first word. While at first your child's language skills will seem to grow slowly, right around the two-year mark they will really take off!

**Facial Expressions:** The meaning of a smile is easy to understand. But you will also get to know your baby's questioning or curious face, along with expressions of frustration,





pleasure, excitement, boredom, and more. Remember, babies experience the same basic emotions we do: happiness, sadness, curiosity, anxiety, frustration, excitement, and so on.

**Gaze:** Look where your baby is looking and it will tell you a lot about what he or she is thinking. An overstimulated or tired baby will often break eye contact with you and look away. A baby who wants to play will have a bright gaze focused right on you or the toy she is interested in!

**Gestures:** Babies use their bodies in many ways to communicate. They reach for people and objects, pick objects up, sweep objects away with their hands, wave their arms and hands and kick their feet, and point (just to name a few). Babies will also turn away from sounds they don't like or arch backwards if they are upset.

## Putting It Together

Babies use their whole body to communicate. So, for example, a baby might focus a bright, clear gaze on a new toy, and then look to you, then back at the toy. She might kick her legs or swing her arms excitedly. The baby might then reach for the toy while making excited "eh eh!" sounds

and smiling. While babies don't think in words yet, the message this baby is sending might be, "What is that thing? I want to see it. Can you give it to me? It looks like fun!"

Or imagine a baby who is happily playing with an older cousin. The cousin is puffing out his cheeks and then letting the air out, making a loud whooshing sound. The baby is laughing, kicking, and waving his arms. All of a sudden, though, the baby's response changes. He looks away and his expression turns to one of distress. He kicks his legs and arches his back. He starts to cry. The message this baby is sending might be, "That was fun for a while. But now it's too much. I need a break."

### 12 Months to 24 Months

In the second year, young toddlers are becoming more skilled at communicating their needs and desires to you. Here are more examples of how young toddlers' communication skills are growing and changing from 12 to 24 months.

**Sounds and Language:** Your young toddler's vocabulary is growing slowly but steadily across his or her second year of life. Pronunciation might not be perfect, like "muh" for milk, but that will

come with time. Your toddler also understands more words than ever before. In fact, he probably understands more words than he can actually say! For example, if you ask him to touch his nose, chances are, he will be able to do so.

Even as your toddler's language skills are growing, cries are still the main way to communicate strong emotions like anger, frustration, sadness, or feeling overwhelmed. You might also see your toddler squeal with laughter and scream in delighted glee when he is too excited for words!

### Facial Expressions and Gaze:

Toddlers make some of the best expressions ever, so keep your camera handy during this second year of life. You can see delight, curiosity, jealousy, and other feelings play across their faces. Young children also use eye contact to communicate with you. For example, you might see your toddler gazing at you to get your attention (Won't you come play with me?). You might also see your child watching you to learn something new (Now how do I press the cell phone buttons?).



# 3

Your toddler also watches your reactions to make sense of new situations (I am not sure I want Uncle Joe to hold me. I am going to check your face to see if you think he is okay or not.) Often you will find that your child mirrors your own expressions and gestures—if you take a bite of broccoli and crinkle your nose, chances are good that your toddler will too.

**Gestures:** Young toddlers are more talented than ever at using their bodies to communicate. They can walk, run, point, take your hand, show you things, carry and move objects, climb, open and shut things, and more. Watching your toddler's body language and gestures will give you lots of information about what she is thinking about, what she wants, or what she is feeling.

## Putting It Together

Over time, it becomes easier to understand your child's cues and messages. Young toddlers are skilled at using their bodies, expressions, and growing language skills to communicate their needs more clearly than ever before. A 14-month-old might creep over to the book basket, choose a favorite story, creep back to her uncle, and tap the book on his leg while saying, "Buh." A 20-month-old might pick up her sandals and then walk to the back door, turn to her grandmother and say, "Go park." These interactions are really an amazing developmental leap for toddlers! They are now able to hold an idea in their minds ("I want to read a book and not just any book, this book") and understand how to communicate that idea to the people who can make it happen!

## Three Steps to Understanding Your Baby's or Toddler's Behavior

When you see a behavior you don't understand, think about these "clues" to try to figure out what the behavior means for your child. Remember, every child is different. The same behavior (for example, a baby who is arching her back while being held) can mean that one baby is tired and that another baby wants to be put down so she can stretch out and play. Getting to know your child's unique cues is an important way that you can show your child that you love and understand him or her.

**Step 1:** Observe and interpret your child's behavior:

- Notice the sounds (or words) your baby or toddler is using. Does your child sound happy, sad, frustrated, bored, or hungry? When have you heard this cry or sound before?
- What is your child's facial expression? What feelings are you seeing on your child's face? Is your baby looking at a new object with interest? Perhaps he is trying to say, "Hand that to me so I can touch it."
- Notice your child's gaze. Is your baby holding eye contact with you or has she looked away? (That is usually a sign that a baby needs a break.) Is your toddler holding your gaze? Perhaps she is trying to get your

attention or wants to see how you are reacting to a new situation.

- What gestures or movements is your child using? Is your baby rubbing her eyes and pulling on her ear when you try to hold her? She might feel sleepy and be ready for a nap. An older toddler who is on the verge of beginning potty training might start to hide behind a chair or go into a closet to have a bowel movement.
- Think about what's going on when you see a behavior you don't understand. Does this behavior happen at a certain time of day (like at child care drop-off or bedtime)? Does this behavior tend to happen in a certain place (like the brightly lit, noisy mall)? Does the behavior happen in a particular situation (like when your child must cope with many other children at one time, like at the playground)?





validate his feelings. If your four-month-old is crying but refuses a bottle, try changing her position—picking her up and rocking her, or putting her down to play.

**Step 2:** Respond to your baby or toddler based on what you think the meaning of his or her behavior is. It's okay if you are not sure if your guess is right. Just try something. Remember, you can always try again. For example, if your 11-month-old is pointing toward the window, lift him up so he can see outside. Even though you might discover he was really pointing to a spider on the wall, the very fact that you tried to understand and respond lets him know that his communications are important to you. This motivates him to keep trying to connect with you. When you respond to your child, say out loud what you think his behavior might mean. For example, you might say to the toddler you pick up, "Are you saying that you want up? I can pick you up." By using language to describe what the child is communicating, you will be teaching your child the meaning of words.

**Step 3:** If your first try didn't work, try again. Trying different techniques increases the chances that you will figure out the meaning of your child's behavior, understand his needs, and

**Step 4:** Remember that tantrums are a communication, too. A tantrum usually means that your child is not able to calm himself down. Tantrums are no fun for anyone. They feel overwhelming and even scary for young children. For adults, it is easy to get upset when you see upsetting behavior. But what frequently happens is that when you get really upset, your child's tantrum gets even bigger. Although it can be difficult, when you are able to stay calm during these intense moments, it often helps your child calm down, too.

Another strategy to try when you child is "losing it" is to re-state how your child seems to be feeling, while reflecting her strong emotions. You might say in a very excited voice, "You are telling me that you just cannot wait for the birthday party! It is just toooooo hard for you to wait! You want to go the party right now!" For some children, having you "mirror" their intense feelings lets them know that you understand them and take them seriously, which helps them calm down. Experiment to see which response works best to calm your child.

**Remember:** You can't always understand what your child is trying to communicate. Even in adult

relationships, we sometimes find ourselves wondering about the meaning of another person's behavior. But these moments—when your child is distressed and you can't figure out why—can be very stressful for parents. If you feel as though you really cannot handle your baby or toddler in the moment, it's okay to put him or her somewhere safe (like a crib) and take a few minutes for yourself. Taking care of you is important. You will make better parenting choices and be able to meet your child's needs more effectively if you are feeling calm and together.

## Wrapping Up

Babies and toddlers experience and express thoughts and feelings. Often they communicate their strong feelings through behaviors that adults understand right away—like a baby's big toothless grin when she sees her grandma coming. Other times, very young children's behavior can be confusing or even frustrating to the adults who care for them. Being able to stay calm, make a good guess at what the behavior might mean, and then respond helps children understand that they are powerful communicators. Over the long-term, this helps children learn how to connect with others in ways that are healthy and respectful—a skill they'll use for life.



The Center on the Social and Emotional Foundations for Early Learning



Child Care Bureau



Office of Head Start



## **Toddlers with autism show improved social skills following targeted intervention, finds NIH-supported study**

Targeting the core social deficits of autism spectrum disorders (ASD) (<http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-pervasive-developmental-disorders/index.shtml>) in early intervention programs yielded sustained improvements in social communication skills even in very young children who have ASD, according to a study funded by the National Institute on Mental Health (NIMH), part of the National Institute of Health (NIH). The study was published online December 8, 2010, in the Journal of Child Psychology and Psychiatry.

Although some research suggests that ASD may be reliably diagnosed earlier (<http://www.nimh.nih.gov/science-news/2007/half-of-children-with-autism-may-be-diagnosable-soon-after-their-first-birthday.shtml>) than the current average age of three years, few interventions have been tested in children younger than 3. During the course of typical development, children learn to interact with others in socially meaningful ways. Measures of social communication include:

- Initiation of joint attention - spontaneously directing others' attention to something of interest, such as by pointing or holding something up to show for social purposes rather than to ask for help.
- Affect sharing - sharing emotions with others through facial expressions paired with eye contact
- Socially engaged imitation - imitating others' actions while showing social connectedness through eye contact.

Deficits in such measures are hallmark symptoms of ASD and can severely limit a child's ability to engage in and learn from interactions with others or from the world around them.

"This new report is encouraging, as the effects on social behavior appear to provide a scaffold for the development of skills beyond the research setting," said NIMH Director Thomas R. Insel, M.D. "We need better early interventions for the core deficits of autism."

Funded through the Studies to Advance Autism Research and Treatment (STAART) Network (<http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-pervasive-developmental-disorders/nih-initiatives/staart/index.shtml>), Rebecca Landa, PH.D., of Kennedy Krieger Institute, Baltimore, and colleagues randomly assigned 50 toddlers, ages 21-33 months old, who were diagnosed with ASD to one of two six-month interventions: Interpersonal Synchrony (IS) or Non-Interpersonal Synchrony (non-IS). Both interventions incorporated classroom-based activities led by a trained intervention provider, and a home-based component involving parents who received specialized education and in-home training.

The interventions were designed to encourage children to make frequent and intentional efforts to engage others in communication or play. The single difference between interventions was that the IS group received more opportunities for joint attention, affect sharing, and socially engaged imitation. The toddlers were assessed at the start and end of the intervention and again six months later.

Children in both groups made improvements in social, cognitive and language skills during the six-month intervention period. Children who received IS made greater and more rapid gains than those in the non-IS group. The researchers also noted that children in the IS group used their newly acquired abilities with different people, locations, and type of activity. This is noteworthy because children with ASD have particular difficulty doing so. They tend to use new skills mostly within familiar routines and situations.

At the six-month follow-up, children in the IS group showed lower improvements in social communication compared to when they were receiving the intervention, but did not lose skills gained during the intervention period. In contrast, children in the non-IS group showed reduced social communication skills at follow-up compared to their performance during the intervention period.

(continued on page 11 Toddlers)

# Early Literacy

From [www.zerotothree.org/BrainWonders](http://www.zerotothree.org/BrainWonders)

## What We Know About Early Language and Literacy Development

Early language and literacy (reading and writing) development begins in the first three years of life and is closely linked to a child's earliest experiences with books and stories. The interactions that young children have with such literacy materials as books, paper, and crayons, and with the adults in their lives are the building blocks for language, reading and writing development. This relatively new understanding of early literacy development complements the current research supporting the critical role of early experiences in shaping brain development.

Recent research supports an interactive and experiential process of learning spoken and written language skills that begins in early infancy. We now know that children gain significant knowledge of language, reading, and writing long before they enter school. Children learn to talk, read, and write through such social literacy experiences as adults or older children interacting with them using books and other literacy materials, including magazines, markers, and paper. Simply put, early literacy research states that:

- Language, reading, and writing skills develop at the same time and are intimately linked.
- Early literacy development is a continuous developmental process that begins in the first years of life.
- Early literacy skills develop in real life settings through positive interactions with literacy materials and other people.

## Early Literacy Does Not Mean Early Reading

Our current understanding of early language and literacy development has provided new ways of helping children learn to talk, read, and write. But it does not advocate "the

teaching of reading" to younger and younger children. Formal instruction which pushes infants and toddlers to achieve adult models of literacy (i.e., the actual reading and writing of words) is not developmentally appropriate. Early literacy theory emphasizes the more natural unfolding of skills through the enjoyment of books, the importance of positive interactions between young children and adults, and the critical role of literacy-rich experiences. Formal instruction to require young children who are not developmentally ready to read is counterproductive and potentially damaging to children, who may begin to associate reading and books with failure.

## What Infants and Toddlers Can Do - Early Literacy Behaviors

Early literacy recognizes that language, reading, and writing evolve from a number of earlier skills. Judith Shickedanz first described categories of early literacy behaviors in her book, *Much More Than The ABCs*. Her categories, listed in the box below, can be used to understand the book behaviors of very young children. They help us to see the meaning of these book behaviors and see the progression children make along the path to literacy.

Early literacy skills are essential to literacy development and should be the focus of early language and literacy programs. By focusing on the importance of the first years of life, we give new meaning to the interactions young children have with books and stories. Looking at early literacy development as a dynamic developmental process, we can see the connection (and meaning) between an infant mouthing a book, the book handling behavior of a two year old, and the page turning of a five year old. We can see that the first three years of exploring and playing with books, singing nursery rhymes, listening to stories, recognizing words, and scribbling are truly the building blocks for language and literacy development.

## Early Literacy Behaviors

### Book Handling Behaviors

Behaviors related to a child's physical manipulation or handling of books, such as page turning and chewing.

### Looking and Recognizing

Behaviors related to how children pay attention to and interact with pictures in books, such as gazing at pictures or laughing at a favorite picture. Behaviors that show recognition of and a beginning understanding of pictures in books, such as pointing to pictures of familiar objects.

Schickedanz, (1999). *Much more than the ABCs: The early stages of reading and writing*. Washington, DC: NAEYC.

### Picture and Story Comprehension

Behaviors that show a child's understanding of pictures and events in a book, such as imitating an action seen in a picture or talking about the events in a story.

### Story-Reading Behaviors

Behaviors that include children's verbal interactions with books and their increasing understanding of print in books, such as babbling in imitation of reading or running fingers along printed words.

## What Young Children Like in Books

### Infants 0-6 months

- Books with simple, large pictures or designs with bright colors.
- Stiff cardboard, "chunky" books, or fold out books that can be propped up in the crib.
- Cloth and soft vinyl books with simple pictures of people or familiar objects that can go in the bath or get washed.

### Infants 6-12 months

- Board books with photos of other babies.
- Brightly colored "chunky" board books to touch and taste!
- Books with photos of familiar objects like balls and bottles.
- Books with sturdy pages that can be propped up or spread out in the crib or on a blanket.
- Plastic/vinyl books for bath time.
- Washable cloth books to cuddle and mouth.
- Small plastic photo albums of family and friends.

### Young Toddlers 12-24 months

- Sturdy board books that they can carry.
- Books with photos of children doing familiar things like sleeping or playing.
- Goodnight books for bed time.
- Books about saying hello and good-bye.
- Books with only a few words on each page.
- Books with simple rhymes or predictable text.
- Animal books of all sizes and shapes.

### Toddlers 2-3 years

- Books that tell simple stories.
- Simple rhyming books that they can memorize.
- Bed time books.
- Books about counting, the alphabet, shapes, or sizes.
- Animal books, vehicle books, books about play-time.
- Books with their favorite TV characters inside.
- Books about saying hello and good-bye.

## Ways to Share Books with Babies & Toddlers

### Make Sharing Books Part Of Every Day

Read or share stories at bedtime or on the bus.

### Have Fun

Children can learn from you that books are fun, which is an important ingredient in learning to read.

### A Few Minutes is OK—Don't Worry if You Don't Finish the Story

Young children can only sit for a few minutes for a story, but as they grow, they will be able to sit longer.

### Talk or Sing About the Pictures

You do not have to read the words to tell a story.

### Let Children Turn the Pages

Babies need board books and help turning pages, but a three-year-old can do it alone. Remember, it's OK to skip pages!

### Show Children the Cover Page

Explain what the story is about.

### Show Children the Words

Run your finger along the words as you read them, from left to right.

### Make the Story Come Alive

Create voices for the story characters and use your body to tell the story.

### Make It Personal

Talk about your own family, pets, or community when you are reading about others in a story.

### Ask Questions About the Story, and Let Children Ask Questions Too!

Use the story to engage in conversation and to talk about familiar activities and objects.

### Let Children Tell the Story

Children as young as three years old can memorize a story, and many children love to be creative through storytelling.

Visit [www.zerotothree.org/BrainWonders](http://www.zerotothree.org/BrainWonders) for more information. BrainWonders is a joint project by BOSTON UNIVERSITY MEDICAL CENTER, ERIKSON INSTITUTE, and ZERO TO THREE.

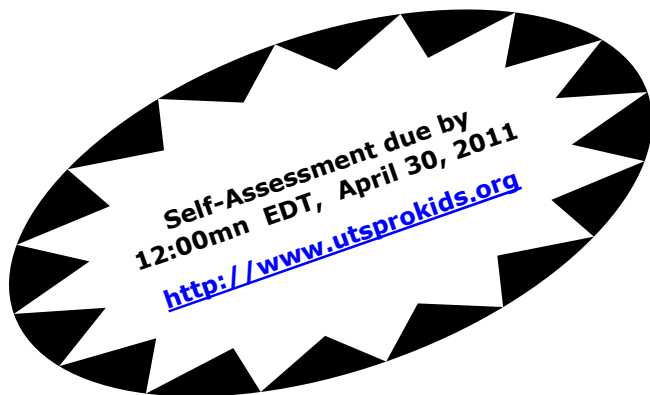


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## **Time to Update Your UTS Account**

UTS training accounts are not linked to provider enrollment. UTS reminds all providers to review and update their provider profile. As providers move to agencies, many are changing email and mailing addresses. CRO Provider Enrollment does not transmit these changes to UTS. Please update your current account, **do not create a new training account, as this will result in a loss of your training history.**

It is important to remember that your provider credential is an individual responsibility and the credential remains with you regardless of any provider referral agreement, contract or employment status you have with an agency. Annual Training Fees (ATF) were due 1/31/11. The ATF must be paid to complete the Training Times assessments.

The state has recently reminded all provider agencies that in order to protect the identity and medical information of clients, phone numbers listed for individual providers must reference their services provided within First Steps. Family and household members should not be answering calls to these lines and certainly should not be taking messages regarding First Steps children and families. Emails should not contain nicknames or dually include or be accessed by the provider and their significant other. The preferred email address is your first and last name with discipline@blank.com.

Updating your account is easy, just log on using your old email and password and type in the new email address and other updates in your Training Profile. Please make sure your correct discipline is listed. If you have questions or encounter problems, please email UTS at [registration@utsprokids.org](mailto:registration@utsprokids.org).